Washington State Employee Assistance Program (EAP)
Network of Contracted Provider Referral Waiver

This form must be completed if you will continue to see the client through their health insurance benefits or private pay after the final assessment session. When referring the client into health insurance benefits or private pay, you are required to provide a minimum of two referrals, to other providers with which you have no financial interest.

EAP Referral Number:

Provider's Name:

Washington State EAP prefers that its contracted providers see our clients for EAP services only. In the event that our clients needs ongoing counseling, or treatment beyond the EAP assessment, we prefer that the contracted provider refer to other professionals or services covered by the client's insurance or available in the community. The employee assistance industry does not encourage self-referrals, as a counselor could recommend additional therapy as a way of generating business for themselves, or their group practice or an organization where they may have a financial interest.

However we understand that in some situations other resources may not be available or that our clients may prefer to continue services with the contracted EAP provider if the provider offers the appropriate ongoing services and are contracted with the client's health insurance benefits. Therefore, EAP does permit its contracted provider to retain the client or self refer. In these situations and to protect our clients from potential conflict of interest, we require the following:

- Provider offers the client two additional referrals (other than themselves).
- Client completes and signs this form.

Referrals	
	Phone:
	Phone:

Client complete and sign below:

I _____, am requesting to continue counseling beyond my EAP assessment and

referral with (provider's name) _____.

I understand that WA State EAP requires its contracted providers to offer at least two additional referrals to clinicians or services beyond themselves, for which they have no financial interest, as this type of situation could present a conflict of interest for me.

- My participation is voluntary.
- I am not obligated to use any of these resources or continue seeing the EAP contract provider.
- I will be responsible to determine if a provider and/or a particular services is covered by my health insurance benefits plan.
- I will be responsible for all services rendered beyond the EAP assessment and referral and benefit.

Client Signature: _____ Date: _____

Submit this form to:
Department of Personnel
Employee Assistance Program
Attn: Contract Manager
701 Dexter Avenue N, Suite 108
Seattle, WA 98109